REVISED 06-26-02

KCDRB Form #7

PHYSICIAN/HEALTH CARE PROVIDER'S STATEMENT

(To be completed by physician or primary health care provider and mailed to patient's employer.)

PATIENT:_____ SSN:_____

EMPLOYER:_____ INSURANCE/HMO:_____

ADDRESS:_____ Insurance billed? Yes ☐ No ☐

CITY/STATE:_____

HEALTH CARE PROVIDER:_____

ADDRESS:_____ Provider's Phone:_____

DIAGNOSIS: I have examined and treated the above-named LEOFF-I member/claimant for the following medical condition(s):

ETIOLOGY: The cause of the condition is:

TREATMENT: I have prescribed or performed the following treatment on the dates indicated. (**NOTE**: For mental health, chiropractic and substance abuse treatment exceeding one month, a treatment plan **MUST** be submitted. Attach KCDRB Form #8, "Physician/Health Provider Treatment Plan".)

☐ In addition, I have attached a medical report/evaluation.

FEE FOR SERVICES: (invoice/statement may be attached).

The services rendered by me and the medication, appliances or other therapies which I prescribed were necessary medical services in view of the patient's diagnosis and condition.

Signature of Provider Date